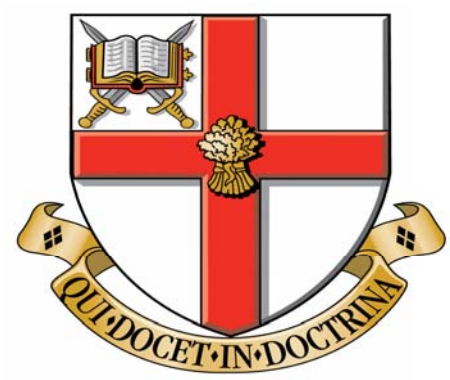

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Organisational Impact of Developing Reablement Services

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Abstract

Under the Community Act, Local Authorities have a legal responsibility to provide an assessment of need to people that require assistance and subsequently commission services that will meet the assessed needs. In 1997 Central Government started to implement a number of social care reforms which prioritised independent living, the building of sustainable communities and empowering service users to have more control and say about the services that they wished to use and access.

As part of these changes Central Government made it compulsory through the National Health Act for Local Authorities and the National Health Service to work closely together to deliver services through partnership working. One of the joint strategic aims is to develop reablement and prevention services to increase people's level of independence thereby reducing the demand for traditional long term care support.

Reablement services are designed to offer short term intensive support which aim to maximise an individual's ability for independence thereby reducing reliance on the need for either residential or nursing care. The development of reablement services presents a massive challenge for the Local Authority and the National Health Service as the change means that two very different organisations have to find a way to overcome a number of organisational barriers to enable workers from both organisations to work successfully together.

This study will analyse the impact of developing reablement services through partnership working and critique how different Primary Care Trusts and Local Authorities are working together to deliver reablement services. This will involve examining different models of reablement, identifying what is required to make a successful model work and determining how the organisations overcome organisational and cultural differences.

The study is based on Liverpool City Council and its work with Allied Health Professionals to deliver reablement services the study will also undertake a comparison exercise with 2 other Local Authorities within England.

Declaration

This work is original and has not been submitted previously for any academic purpose. All secondary sources are acknowledged.

Signed: _____

Date: _____

Contents

1. Introduction

1.1. Background to the research

1.1.1. Organisational background

A number of Local Authorities (LA) across the United Kingdom have chosen to commission long term social care packages through independent social care providers in the belief that an outsourced contract provides better Value for Money in the longer term (VFM). It is widely recognised that the cost of providing in-house services is more expensive due to the terms and conditions that Public Sector staff receive.

Rather than lose the skills and experience of qualified social care staff employed in the Public Sector many LA have concentrated on utilising the existing workforce to deliver specialist services that are not widely available in the independent sector. Specialist services concerning social care are considered to be those that offer something different or unique to the more traditional services. For example social care staff that work in rehabilitation and enablement require certain skills and competences above that of a mainstream home carer.

LCC has developed a specialist Assessment and Rehabilitation Team (ART) which provides short term support to people being discharged home from Hospital. The aim is to assist people to regain their skills and ability for independence. The ART team provides human resource to the Primary Care Trust by supporting the work of Allied Health Professionals (AHP). AHP is a team of qualified Occupational Therapists that undertake assessments and if appropriate for enablement refer to ART for support. The arrangement with the PCT regarding ART support is currently informal.

The Primary Care Trust is reviewing its commissioning strategy and has approached LCC about formally commissioning a reablement service from the Authority. The plan would involve formalising the current working arrangements between the PCT and LCC. This in itself would represent a massive challenge for both organisations because although the informal arrangement has its merits there are many cultural differences that create tension and conflict between the representatives of each organisation.

1.1.2. Academic background

"It is clear that, in relation to service failure, problems often occur at the borders between one organisation or team and another" (Health Care Commission, 2008) quote Integrated Governance journal……

The development of reablement services poses a number of challenging issues for the PCT and LCC. Although each of the organisations share similar political drivers and are expected to conduct joint strategic needs assessments each organisations will have individual priorities based on the needs of their particular business.

Doyle and Cornes (2006) suggest that proposals for Health and Social Services to work together can be fraught with problems because historically health led organisations have always attempted to be the dominant force when working with partners in Social Services.

Furthermore a report by Wistow and Waddington (2006) discusses an attempt to integrate Health and Social Service management structures between English Boroughs in Barking and Dagenham. The reports highlights that the organisations ran into difficulties mainly due to incompatibilities that stemmed from a mismatch of cultures.

The ability to overcoming these problems can be the difference between success and failure. This research project will aim to identify the critical success factors that are key to helping Local Authorities and Primary Care Trusts to effectively merge organisational structures and culture effectively to deliver reablement services.

1.1.3. Research question

The aim of this study is to assess the impact of developing reablement services which are developed by Local Authorities working in partnership with the Primary Care Trust. The primary purpose will be to explore the different approaches Local Authorities are adopting with Primary Care Trusts with regards to the development of reablement services.

In addition the research will aim to identify how each organisation tackles organisational change particularly those changes which have the greatest workforce impact. The research will also consider how the medical model compares with the social model with a view to determining what if any impact these models have on each other with regards to Health professionals working with Social Service staff.

The study will involve studying the history of both organisations with the aim of identifying and considering the contemporary issues which influence the behaviour and culture of each organisation.

1.1.4. Research question

The organisational impact of developing reablement services

1.1.5. Aims of the investigation:

2. To assess the strategic impact of developing re-enablement focussed services

3. To understand contemporary literature about how Local Authorities and Primary Care Trusts are working in partnership to deliver re-enablement services

4. To assess the potential operational issues that stem from developing re-enablement services

5. To draw conclusions and make recommendations based on outcome of research

1.3. Justification for the research

LCC provides a range of home care and residential based services that provide care and support to some the most vulnerable adults in the Liverpool. Current forecasts based on national statistics indicate that people are tending to live longer due to advances in health care treatments and an overall improvement in the standards of living.

This places a greater demand on Public Services because as people grow older there is an increased possibility that at some point in their lives individuals may require some form of help or support from the NHS system and their Local Authority. This will be due to the consequences of age related diseases; therefore although people are generally living longer the risk of contracting an age related illness still remains high.

Current projections suggest that that UK costs for long term care could double between 2000 and 2050 as a consequence of increased life expectancy. This will potentially place an enormous pressure on Public Service budgets in the future. According to current data (NHS MA, 2005) it is estimated that upwards of 17 million people are living with long term conditions (LTC) that require social and health care treatment.

Caring for people with LTC in the community is now a key driver for government policy due to the social and economic implications associated with LTC. It is suggested that 80% of General Practioners (GP) consultations relate to LTC and the NHS modernisation agency has predicted that by 2030 the incidence of chronic disease in people over 65 will have doubled. A worrying statistic is that over 5% of people with LTC admitted to Hospital occupy 42% of all beds.

Bowes (2007) suggests that one way of controlling the cost of long term care is to consider the models provided and their organisation. Research considering the cost impact of different models suggests that home and community based support is a much more efficient and effective use of resources in the long term. Promoting independence is a cornerstone of social services policy due social care reforms that require Public Services to be outcome focussed whilst also delivering services within budget by achieving efficiency targets and VFM. Reablement services are generally viewed as the best system for promoting and increasing levels of independence.

LCC is currently considering proposals to develop reablement services though a process of local re-engineering and a formal service review. The findings of this research will underpin the proposed changes.

1.4. Methodology

As this will be a qualitative study an interpretivist style of research will be adopted, Fisher (2007) suggests that “interpretivist research seeks people’s accounts of how they make sense of the world and processes within it”.

Interpretivist research undertaken by Dawson (1994) characterised the approach as “involving competing histories or interpretations of events and politics and political processes are integral to an understanding of issues”. The political drive to deliver

"joined up Government" means that staff from very different backgrounds will have their own perceptions and values that will influence their response and attitude towards integrated services. The interpretivist approach will be useful in this respect because as Fisher (2007) suggests "you cannot understand how others make sense of things unless you have an insightful knowledge of your own values and thinking processes".

The research will involve interviewing NHS and Local Authority staff that are involved in delivering reablement services. The aim will be to conduct face to face interviews to establish how each model operates and to understand how each organisation deals with issues related to governance, organisational culture and change.

A literature review will be undertaken to research the impact of developing reablement services considering organisational culture, workforce implications and change management.

1.5. Outline of the chapters

1.5.1. Chapter 1 - Introduction

This chapter explains the subject of research concerning the future cost of providing long term care and describes how alternative support such as reablement services could potentially offer Public Services the best solution to controlling the market. It will discuss the political drivers and review the options available to Local Authorities.

1.5.2. Chapter 2 – Literature Review

The review will consider current theories regarding the NHS and Local Government Organisations working in partnership to deliver reablement services that are designed to promote independence and reduce the need for long term care.

This details the current theoretical thinking around social care sourcing and change management within a public sector organisation. Literature sources include:

International Journal of Public Sector Management, Journal of Health Organisation and Management, Journal of Management in Medicine, and electronic sources from

relevant websites including CSED, RIPFA CSCI, CSIP, DoH, and Local Authority websites.

Further knowledge will come from literary publications around Organisational Culture, Theory of Change, Governance and Leadership studies.

1.5.3. Chapter 3 – Methodology

Methodology will give information around the research concept adopted, and the research tools used to inform the study.

1.5.4. Chapter 4 – Findings

This chapter will present the findings of the study, based on the responses collected from the interviews conducted and presented in such a way as to inform the reader. Conclusions from this chapter are presented in the following chapter.

1.5.5. Chapter 5 – Conclusions

All of the data collated and presented in chapter 4 will be analysed and interpreted in this chapter. Conclusions will be drawn and linked back to the research aims, and where appropriate, opportunities for further research identified.

5.1.1. Chapter 6 – Recommendations

This chapter will provide recommendations based on findings and conclusions and detail a recommended implementation plan.

1.5.6. Definitions & Glossary of Terms

Term Used	Definition
AHP	Allied Health Professionals
ART	Assessment and Rehabilitation Team
CSED	Care Service Efficiency Delivery
HART	Home Assessment and Rehabilitation Team
KCC	Knowsley City Council
LTC	Long Term Care
LCC	Liverpool City Council
NHS	National Health Service
OT	Occupational Therapist
PCT	Primary Care Trust
RT	Reablement team
SS	Social Services
SW	Social Worker
WCC	Wirral City Council

1.5.7. Summary

This chapter has introduced the research question and aims of the study. The research is justified and the methodology is briefly described. Limitations to the study are detailed, and the layout of the report is outlined. The following chapters will take the reader through the research journey and ultimately answer the research question.

2. Literature review

2.1. Introduction

This chapter will explain the background to the research question with regards to reablement, particularly with regards to examining Central Governments policies concerning the promotion of the countries Independence, Health and Wellbeing. The study is grounded in literature research, including sources taken from the following journals;

International Journal of Public Sector Management, Journal of Health Organisation and Management, Journal of Management in Medicine, and electronic sources from relevant websites including CSED, CSCI, CSIP, DoH, and Local Authority websites.

Further knowledge will come from literary publications around Organisational Culture, Theory of Change, Governance and Leadership studies.

2.2. Parent disciplines/fields/themes

The key themes informing this study are organisational culture, reablement, change and partnership working with specific regard to Central Governments agenda concerning promoting independence through the development of reablement services.

2.3. Social Care Policy

The 1998 White Paper, Modernising Social Services (Secretary for Health, 1998 a) advocated independent living that centred on the needs of individuals and their families. The paper expressed concerns about the lack of respite and rehabilitation services and recommended the need for and effective risk assessments to target low level support on people most at risk of losing their independence.

According to current data (NHS MA, 2005) it is estimated that upwards of 17 million people are living with long term conditions (LTC) that require social and health care treatment.

Caring for people with LTC in the community is now a key driver for government policy due to the social and economic implications associated with LTC. It is suggested that 80% of General Practioners (GP) consultations relate to LTC and the

NHS modernisation agency has predicted that by 2030 the incidence of chronic disease in people over 65 will have doubled. A worrying statistic is that over 5% of people with LTC admitted to Hospital occupy 42% of all beds.

The National Service Framework for Older People (DH, 2001) highlighted the need to develop services that prevented premature admission to long term care, while in 2006 Our Health, Our Care, Our Say recommended that social care should be delivered closer to home, and improved rehabilitation (DH, 2006) principles that underpin the principles of the development of reablement services. Wistow, Waddington and Godfrey (2003) define prevention as preventing or delaying the need for high cost care as a result of ill health or disability due to aging.

The 1998 White Paper, Modernising Social Services, places greater emphasis at putting independence at the heart of social services and reiterating that "social services must wherever possible aim to help people to get better, to improve their health and social functioning rather than just keep going" (Secretary of State for Health, 1998).

The Wanless Social Care Review (2006) Securing Good Care for Older People: Taking a long-term view states that "Preventative services have become increasingly prominent in health and social care policy in recent years, in part to the because of the perceived potential to reduce demand for high intensity, high cost services" (p169)

The White Paper: The New NHS. Modern, Dependable (Department of Health, 1997) clearly demonstrated that Central Government placed joint working at the heart of the policy and incorporated a duty of partnership working on local and health social care agencies. The issuing of joint national priorities guidance for health and social services has set a co-ordinated framework for national social policy change.

In response to the political pressure to promote independence, many local authorities have identified re-enablement services as a core specialist competency (Drake and Davies, 2006). Fisher (2008) suggests that there has been a steady decline since 1993 concerning the number of people receiving home care, despite an increase in the number of people receiving short term intensive support.

This would suggest that the reductions in home care have been a consequence of tighter eligibity criteria's being operated as opposed to a "positive effect" of receiving intensive home care for example reablement. This strategy is not popular as Fisher (2008) concludes "that it is unpopular to withdraw services from a large number of people to make more intensive service available to a smaller number".

The rationale behind the idea of re-enablement is that short term interventions can reduce the need for expensive long term complex care at home, reduce admission rates to traditional care home settings and avoid unnecessary admission to Hospital.

Conversely however an earlier study conducted by Burton (1995) questioned the validity of this belief. Burton analysed evidence based on 2 year study of 4000 older people in the United States of America that lived at home. One group received short term preventative intervention whilst the second group received long term care. The study concluded that there were no significant differences in cost between the two groups. The study highlighted that whilst some preventative support may result in some short term savings, they may not actually contain the long term costs, particularly those associated with ageing.

However Central Governments vision for citizens is aimed at giving people the right to live at home independently for as along as possible and reablement remains high on the national agenda. Drake and Davies (2006) state that a lot of local authorities are innovating in certain types of specialist care, some in partnership with other bodies such as local health authorities.

2.3.1. Reablement

The 1998 White Paper, Modernising Social Services (Secretary for Health, 1998 a) The White Paper places greater emphasis at putting independence at the heart of social services and reiterating that "social services must wherever possible aim to help people to get better, to improve their health and social functioning rather than just keep going". The Secretary of State for Health reiterated a very clear and resounding message by stating "we are looking at major cultural change for everyone. There is a need to develop organisations to support a change in culture and to deliver change"

Following the general election in 1997, a ten year programme of modernisation was outlined. The emphasis was to deliver high quality person centred care that would extend across health and social care boundaries. The reforms involved transforming public sector services to become customer focussed and accountable through large scale programmes of change and modernisation.

The modernisation plans aimed to change the philosophy of care, emphasising the need for service user involvement in the planning and delivery of care; improvement in access to services, more care to be provided in the community through intermediate care and increased partnership working between health and social services.

Intermediate care evolved in the context of the NHS Plan to provide a seamless service that transcended established health and social care boundaries. Intermediate care is broad term used to describe services that assist a person to move from medical dependence to personal independence. Services that are classed as Intermediate Care such as reablement are provided for a period of 6 weeks and are free of charge during this period.

Promoting independence underpins social care policy and within this an awareness of demographic pressures and the growing priority on achieving outcomes has meant that reablement services are becoming increasingly important.

According to CSED (2007) across health and social care the terms reablement, enablement, rehabilitation and intermediate care tend to be used differently, and the distinction between the services is blurred. Moreover, Martin et al (2004) suggests that the term intermediate care is open to interpretation and also suggests that the diversity in service prevents the development of evidence based outcomes for patients and cost efficiency purposes.

A study undertaken by CSED (2009) reported that a wide diversity of intermediate care services, with variances with regards to access, settings and destinations to which users move to following a period of rehabilitation. Barton et al; (2005) suggests it is difficult to evaluate each system due to the high level of variance, although Godfrey et al (2005); imply that qualitative evidence from service users suggests intermediate care can make a difference to peoples lives. However there is insufficient evidence

provided by Godfrey to substantiate the claim with regards to the profile of those interviewed or the treatment that they received.

CSED (2007) stated that its research had not unearthed one comprehensive scheme that has been independently evaluated by an academic unit, completed a longitudinal study and routinely monitored service provision. However, during the last 2 years further research has been undertaken and an in-depth analysis of reablement has been conducted by the Social Policy Research Unit (SPRU) at the University of York (Interim Report, Short-term Outcomes and Costs of Reablement Services, 2009)

The research has involved a study of enablement services operated by various authorities.

An analysis of the outcomes achieved by individuals that received a period of reablement showed that significant benefits could be achieved by users by increasing their level of independence. The research showed that on average a reduction of commissioned hours has been achieved by those undergoing a phase of reablement when compared to a group that had not (table1.)

Table 1.

	Received Reablement	**Did not receive Reablement**
Discontinued	58%	5%
Decreased	17%	13%
Maintained	17%	71%
Increased	8%	11%
Total	100%	100%

However although the analysis shows a reduction in care following a period of reablement CSED confirm that it is difficult to identify whether the individuals that received reabalement would have recovered their independence without reablement.

CSED have developed a clear definition to distinguish the differences between prevention, rehabilitation and reablement. CSED describe reablement as being services for people with poor physical or mental health to help accommodate their illness by learning or re-learning the skills necessary for daily living.

The philosophy is to help people to do things for themselves rather than having things done for them. The DOH report "Transforming Social Care" (2008) outlined that this change would present a huge challenge as it would affect how professionals engage and work to support people's needs. Home carers are being trained to deliver reablement however Sinclair et al. (2000) reported that there was evidence that suggested that home care workers habitually did things for their clients which the organisation proscribed and often took it upon them-selves to make their own decisions with regards to meeting the wants and needs of the client.

According to Sinclair et al. (2000) the home care service began in an atmosphere of austerity whereby "home helps" would be used to support reasonably fit older people with low level tasks such as shopping, laundry, pension collection, domestic cleaning and lighting fires. This form was provided until the 1980s however the growth in the number of older people requiring support has put many local authorities under strain.

Furthermore Sinclair et al (2000) reports how financial pressures on the health service and the closure of geriatric wards has decanted some of the pressure on to social services. Due largely to the recent reforms in health and social care, home care staff have experienced a major change in role with a much stronger emphasis on promoting independence. However the structure that home care staff work under is largely unchanged in as much that staff are required to work unsupervised in a person's home with occasional visits being made by their manager, therefore there is a risk that some staff may choose to work in the manner that home helps did in the early 1980s.

All services classed as Intermediate Care are free of charge for a maximum period of 6 weeks. Sinclair (2000) noted that in "one authority clients discharged from hospital with an intensive free service apparently stopped all services when payment was eventually requested". The period of free service should in theory aim to reduce the level of need, however the danger is that when service users cancel services altogether

there is an increased risk that the person may deteriorate further leading to more complex and costly care being required as a consequence.

In 2006 CSED reported that 24 percent of councils in England had a home care reablement service; 16 percent had a limited service and they were planning to expand; and 26 percent were planning to establish a home care reablement service. A more recent update survey published by CSED found that 106 councils now had reablement services in place, were seeking to expand an existing service or were in the process of establishing a service.

CSED report that there are variances in the structures of reablment teams, for instance some are funded and delivered by the NHS in partnership with the local authority. These types of partnership models involve occupational therapists and physiotherapists supporting trained home care staff to carry out therapy led programmes of care.

In contrast some council's prefer to develop reablement through their home care service usually as a result of a service review and re-engineering, these models may not be delivered in conjunction with therapists, although a therapist may become involved if an assessment for equipment is required. Therefore the main difference between the two models is that one will be led by health care professionals whilst the latter will be social care led.

CSED reported that in Wirral the therapy led reablement model was developed because OT staff reported that when care was provided by social services, staff tended to do things for people rather than enabling them to do things for themselves. The OT staff believed that this way of working only created dependence and therefore people didn't improve or progress as expected.

In contrast other LAs have changed from traditional long term care to reablement due to market forces and increased competition from the independent sector. Some LAs choose to reduce the size of their home care service to focus on providing a much smaller specialised service that aims to help people to regain or maintain independent living at home.

According to Waddilove (2006) hybrid roles are becoming more common across the health and social care sector in response to the need for multidisciplinary teams to work closer together through partnership working. Waddilove uses the example of Community Support Assistants that are trained to deliver low level nursing therapy and rehabilitation to adults who receive personal care and nursing input at home.

A CSED report published in 2009 describes how home care staff have been trained by an OT to assess for minor adaptations, such as grab rails and could order them direct from a supplier without the involvement of an OT. Although an earlier report published by Sinclair et al. (2000) reported that in some situations there was evidence of professional uncertainty with regard to sharing information and trusting the judgement of home care staff.

This would appear to be validated in the recent CSED report (2009) as a reablement manager is quoted as saying that one of the barriers that they had to overcome was a shift of thinking that only people with professional qualifications can make decisions to one that gave credibility to vocationally qualified staff too.

In the report there is also evidence that OT staff raised concerns about the quality of assessments undertaken by social services. The OT staff stated that social service assessment relied heavily on what a patient or their family thought they could do for themselves. Whereas the OT staff believed that there assessments were much detailed and relied on factual information rather than self reports from patients.

CSED have predicted that demand for home care will rise as a consequence of those aged 85 rising to 12% by 2012 and 45% by 2022 this will inevitably lead to an increased demand for social care and support from the Local Authority. Without reablement there is an increased risk that some people may become unnecessarily dependant on the Local Authority for support

Wanless (2006) suggests there has been a 5% reduction in the number of care home beds and the prediction is that this reduction will continue as Local Authorities attempt to redirect funding to home based support. Conversely however Wanless also suggests that this trend could falter because an admission to a care home may prove to be the only viable option for those suffering from a cognitive impairment.

This creates a paradox as there is a distinct possibility that in the future there will be insufficient care home beds available within the system and although there will be increased community support this may not be sufficient to meet the needs of those that will require long term complex care which could only be met in care home environment.

2.3.2. Partnership working

To promote independence staff from diverse professions and organisations will have to work together across conceptual and organisational boundaries (McMurray, 2006).

The terms collaboration and teamwork are now espoused frequently when referring to the health and social care sector (Hunter, 1996). Equally integration and partnership working are references which are commonly used when discussing the delivery of improved health.

According to Wistow (2001) Labour Government is advocating "joined up" Government to tackle the causes of poverty and social exclusion, not just the symptoms. Labour policies for Health and Social Wellbeing include reforms that include the need for local authorities and the health service to develop joint strategies to build sustainable communities.

The 1998 White Paper "Modernising Local Government" (DETR, 1998) focuses on accountability of public services to local citizens and active involvement and engagement of local communities and local decisions.

In addition the "Local Government Act" 2000 places principal local authorities under a duty to prepare community strategies for promoting or improving economic, social and environmental well-being of their areas and so contribute to the sustainable development in the United Kingdom (Wistow, 2001).

Building sustainable communities is seen a panacea for tackling the many problems and social difficulties faced by many communities across the United Kingdom, including crime and community safety, the environment, health, housing, education and transport. There is a general consensus that health and social needs are intrinsically linked and therefore a holistic approach is required to improve the health and wellbeing of communities.

The reforms prioritise the need for increased partnership working in recognition that policy outcomes cannot be achieved by social and health care organisations working in silo of each other (Flynn, 2007).

“Central Government initiatives include legislation and statutory duties aimed at forcing organisations to work together and funding steams predicated on inter-organisational working and resulting in new ways of working across organisations” (Ling, 2002).

Conversely however, McClenahan and Howard (1999) suggest that enforcing partnerships will only serve to create tensions and conflict within the workforce which will ultimately lead to failure. They further add that partnerships usually consist of one partner being a dominant force which can instil a feeling of takeover in one set of staff, thereby leading to tension, distrust and annoyance.

Glasby (2005) argues that the rationale behind the reforms started in 1997 are not new and identifies a number of parallels between reforms made in the last decade to those undertaken in the late 1960s. Glasby discusses a review undertaken by the Seebohm Committee which was tasked “to review the organisation and responsibilities of the local authority and personal social services in England and Wales and to consider what changes are desirable to secure an effective family” (Seebohm, 1968, p.11).The review recommended that that local authorities should work closer with other services such as housing, health care and education In addition the report recommended that social services should be directed to treat the well-being of the whole community as opposed to only assisting or intervening when a person was in crisis. These recommendations mirror current reforms reflected in the NHS plan and the 1998 white paper Modernising Social Services.

Similarly the Barclay Report (1980-1982) published findings of a two year review of the role and tasks of social workers. The report emphasised the need for social services to work closely together with other services however, identified that this would be difficult as social services used a targeted approach unlike universal services such as health, education, housing and the police.

Furthermore the Barclay report identified professional and organisational barriers that would make joint working difficult for example issues of accountability, different geographical boundaries and lack of understating about each other roles.

Evidence suggests that that there has been a history of false starts and unfilled potential with regards to partnership working between the health and social care sector and Hudson (1999) warns that previous experiences "should serve to warn against undue optimism".

Under the Health Act (2006) Section 75 agreements enable health and social services to have "flexibility" regarding collaboration, joint working and pooled budgets. Other flexible options could include service level agreements and local area agreements. However from a workforce point of view the section 75 agreement creates a number of risks and challenges when services are integrated such as TUPE and potential changes to employee terms and conditions.

Central Government places great emphasis at putting independence at the heart of social services and reiterating that "social services must wherever possible aim to help people to get better, to improve their health and social functioning rather than just keep going" (Secretary of State for Health, 1998). However, Maddock (2002) suggests that "ministers call for innovation but few know what this involves or how to go about it "the government is good at knowing what needs to change but poor at working how to create incentives for change"

In a review of partnership working in the public sector the Audit Commission noted:

"Working across organisational boundaries brings complexity and ambiguity that can generate confusion and weaken accountability. The principle of accountability for public money applies as much to partnerships as to corporate bodies. The public needs assurance that public money spent wisely in partnerships and it should be confident that its quality of life will improve as a result of this way of working. Local public bodies should be much more constructively critical about this form of working as it may not be the best solution in every case. They need to be clear about what they are trying to achieve and how they will achieve t by working in partnership" (Audit Commission, 2005, p2)

2.3.3. Organisational Culture

Culture is " the outcome of the shared experiences arising from an organisations attempts to resolve fundamental problems of adapting to the external world and achieving internal integration and consistency and this constructs a collective pool of knowledge that determines what is appropriate behaviour, directs understanding and gives guidance on how to resolve problems" (Schein, 1985).

According to Brookes (2003) culture includes the way people think, behave and even look. Brookes adds that there can be differences in beliefs, values and different interpretations of things around them.

A clash of organisational culture is reported as a major factor the can lead to partnership failure, problems such as different ways of framing issues, reacting to problems, following different procedures, differences in management style have all been cited as creating an us versus them situation (Marks, and Mirvis, 1992).

The variance in culture can be evidenced in the NHS, for example a series of subcultures exists between different professions for example Doctors, nurses, ancillary workers and managers (Brookes, 2003). Davies et al. (2000) also suggests that different cultures may emerge, for example between different occupational or professional groups for example between health and social care workers.

A report by Wistow and Waddington (2006) discusses an attempt to integrate health and social care management structures between English Boroughs in Barking and Dagenham and highlight that the organisations ran in to difficulties due to incompatibilities because of a mismatch of cultures. Wistow and Waddington summarise the characterisation between NHS and social service partners as follows:

NHS	**Social Services**
Treatment	Care
National Targets	Local needs
Must do's	Local discretion
Universal services	Focus on vulnerable
Procedurally regimented and very top-down style	Practical focus but has difficulty with strategy and planning

Due to the recognised cultural differences between health and local authorities Doyle and Cornes (2006) suggest that proposals to work in partnership can be fraught with difficulties because historically health led organisations have always attempted to be the “dominant force” when working with partners in social services.

However the landscape is now changing as Wanless (2006) points to the fact the modernisation of health and social services will bring about change in roles and responsibilities of the different professions with the role of social care becoming increasingly important.

This would suggest that social care will play a more important and prominent role in the modernisation of health and social care, however the paradox is that this comes at a time when many local authorities have chosen to outsource social care to the independent sector with the aim of creating specialist role such as reablement models. Drake and Davies (2006) suggest that these restructuring exercises can result in “hollowing out” whereby the outsourcing organisation leaves it self with a skeletal workforce that is unsustainable.

Wistow (2001) draws attention to model of care which underpins the NHS, stating “ that the NHS apparently remains patient rather citizen centred, its emphasis is on patients as relatively passive consumers of care rather than active partners in retaining or regaining their health and active citizens in shaping decisions about policy or service delivery”.

Political drivers such as developing sustainable community strategies through joint strategic needs assessments is quite challenging for the NHS as Wistow (2001) suggests that Local Government agencies have more knowledge and experience of community involvement and engagement than does the NHS.

Gage (1998) also suggests that professional cultures are typified as “ possessing values that run counter to the spirit of collaboration due to the high value which they place on autonomy” although Hall (2005) argues that that “these differences not only pertain to different models of health care underpinning these professions but also relate to deeply engrained factors such as class and gender”.

Glasby and Lester (2004) highlighted the problems that can occur when members from particular professions attempt to work together, they point to the conflict that results from uni-professional cultures and the absence of shared philosophies.

One of the tensions between the NHS and Social Services is he recognised differences between the medical and social models of care which are two very different paradigms. For example the medical model will view people as patients (treatment) whilst the social model will go beyond the physical and concentrate on the overall needs of the individual (care).

McMurray (2006) refers to the medical model as seeing clients as objects in need of repair and one which is characterised by the opinion of the expert and treating physical causes of illness. Whilst the social model of care advocates enablement, care and emphasises maintenance of wellbeing and interaction with the whole person.

Kharicha et al (2005) cited cultural differences as existing between the medical and social model of care. The main barriers being defined as lack of understanding of and clarity over each other roles, responsibilities, procedures and organisational procedures.

Davies et al. (2000) adds that that there can be different levels of power and influence within an organisation whose dynamics may change over time, Davies uses the medical culture in the NHS as a prime example to demonstrate how health care is "notoriously tribal".

Wistow (2001) suggests that one of the risks on integrating social services with the NHS is that the values ands skills that underpin the field of social work and social care will become subordinate to medical or nursing models. Interestingly in 1968 Seebohm actually suggested in his recommendations that the values of social work should be kept distinctly separate from that of the medical model. However, this would be appear to be contrary to current thinking with regard to partnership working between health and social services.

There are also differences in the professions concerning risk, for example the medical model veers on side of caution whilst the social model should advocate the human right to take balanced risks. Although the National Audit Office (2000) reported that

the Public Sector is strewn with blame and risk adverse culture commenting that this was a “real barrier to modernising services”. This would suggest that the NHS and public sector are both to some degree risk averse.

CSED (2009) reported difference of opinion between health and social care workers regarding the most effective skill mix for a re-enablement service. Some contributors felt that having Occupational Therapist (OT) involvement might lead to a more medical approach being adopted and were concerned that health professionals in general were more risk adverse which might lead to an over cautious approach to some service users.

In contrast some qualified OT staff believe that unqualified social care staff may find it difficult to become an enabler because historically social care staff have always “done” things for people rather than helping people to help themselves.

Wilson et al. (2007) highlight that the relationship between the NHS and Local Government providers has been characterised by arguments and conflict through various reforms and reorganisations. In this regard Glendinning, Hudson and Means (2005) suggest “that a reoccurring theme is the imbalance between the health and social care sectors, with the NHS commanding most of the resources and taking actions where the consequences impact upon the local authority social care services for instance discharge from hospital to the community”. An example of this imbalance is when Hospitals cross charge the Local Authority £100.000 per day for individual delayed Hospital discharges that occur this can apply even if the Local Authority has not been at fault for the delay.

Larkin (1983) refers to medical dominance describing the extent to which the profession of medicine was able to control authority over its knowledge and task domain and extend this power to control the knowledge, skill and role boundaries of other healthcare professions. Although Larkin applies the medical dominance theory to the healthcare profession there is no doubt that the consequences extend as far as the relationship between health and social care professionals.

“Occupational imperialism refers to the attempts by a number of occupations to mould the division of labour to their own advantage. It involves tactics of poaching skills from other or delegating them to secure income, status and control. The medical

profession has clearly been the most successful in these spheres, but it is not the only group with an interest in controlling the division of labour" (Larkin, 1983). Central Government plans regarding the integration of health and social services inevitably means that some professional roles will be devolved to non professional staff placing some roles and professions at risk.

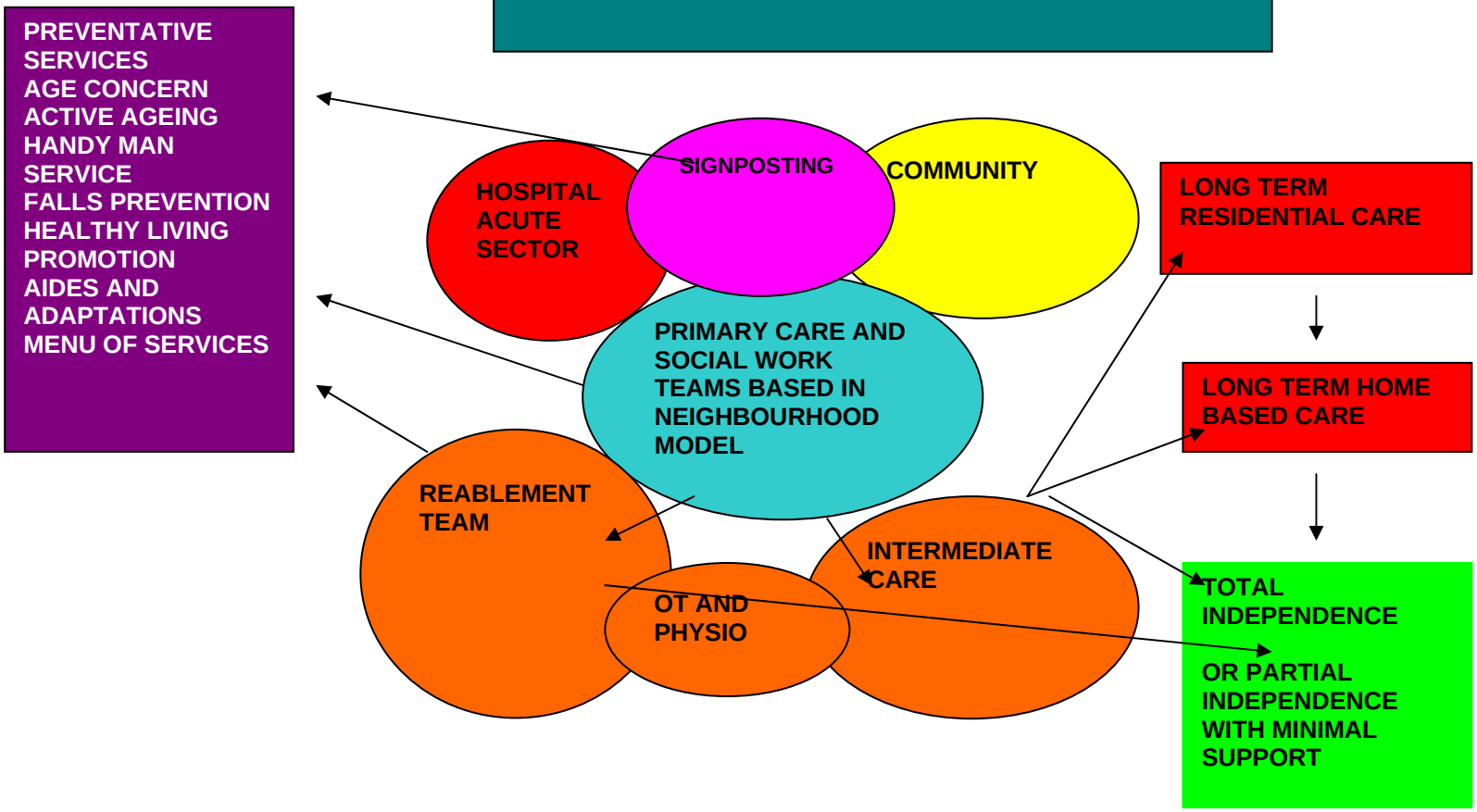
Carrier and Kendall (1995) refer to the "concept of a hierarchy of professions differentiated by full and semi professional status has particular relevance for health and social care professions which have contrasting histories and contrasting contemporary circumstances on legal registration and rights to practice.

Wistow (2001) discusses how the NHS has "cast social services in the role of handmaiden" a role based on providing just in time contributions to helping to move patients from Hospital and thereby creating room for the next group of patient in need of treatment.

Maddock and Morgan (1998) argue that doctors in the medical profession view themselves as the gatekeepers of health care and as such the medical profession guards its members and its traditions and by doing so impedes the development of community and primary health care.

The evidence produced by CSED (2009) suggests that some health care professionals continue to have doubts about the social care assessments and the ability to deliver reablement focussed services. The perceived threat which stems from the notion of de-professionalising some roles may make the integration of some health and social care teams difficult.

CONCEPTUAL MODEL



2.3.4. Conceptual Model Explained

The reablement model is based on the concept that support which aims to maximise independence should in theory reduce the need for long term complex care in the future. The time period that an individual remains in Hospital following admission can affect levels of independence. Intermediate Care aims to continue a plan of treatment outside a Hospital setting with the aim of providing short term intensive support either at home or at an intermediate care unit. In Hospital a person will receive treatment that will address their physical condition whereas Intermediate Care will aim to increase independence levels by working to address the effects of the condition by helping an individual maximise their level independence either through exercise programmes designed by a Physiotherapist and or the provision of equipment which has been prescribed by an Occupational Therapist.

Reablement forms part of the Intermediate Care model and can include social care staff working directly under the supervision of therapists. However there is scope for social care staff to deliver reablement that doesn't require professional input such as low level help and assistance. Reablement outcomes can be considered as the following:

- Full independence achieved and no further care is required
- Independence increased but reduced level of support still required
- Needs could not be improved and admission to long term care institute or complex long term home care required

Intermediate Care avoids inappropriate hospital or care home admission, by avoiding delay which can lead to deterioration and crisis and by providing community based support with access to expert assessment, diagnosis and treatment. Reablement services help to ensure that people receive the right level of support at the right time and therefore provide system wide benefits. For example a the likelihood of a hospital re-admission or an admission to long term care will be reduced within a system that has a reablement service alongside a wider enabling culture within care services. Equally there will be population wide benefits as people are more likely to contribute

to neighborhood and society, particularly where local neighborhood through voluntary organisations or similar networks plays a part in the reablement process.

2.3.5. Summary

This chapter has discussed established theories around the development of reablement services, partnership working between the NHS and Local Authorities and discussed organisational culture with regards to the Health Service and Local Government. LCC and the Liverpool PCT have developed a conceptual model which is being implemented across both organisations to reduce unnecessary admissions hospital, facilitate timely discharges and increase the number of people receiving care at home. The aim is reduce the number of people requiring long term care through prevention, rehabilitation and reablement.

The model has assisted the PCT and LCC to reduce the number of delayed discharges from hospital and increased the level of support delivered at home as opposed to a residential care.

The following section will detail the research methods and instruments in establishing the key success factors behind successful reablement teams in addition to determining the organisational impacts of reablement.

3. Methodology

3.1. Introduction

This chapter details the methods undertaken during the research project, including the philosophy chosen, the strategy taken, the instruments used and ethical factors considered.

According to Saunders, Lewis and Thornhill (2007) the choice of research philosophy that a researcher adopts contains assumptions about their view of the world. Johnson and Clark (2006) suggest that the choice of research strategy is significant as the chosen philosophy informs not only what we do but also what we understand about the topic we are researching. Furthermore Johnson and Clarke (2006) believe that a researcher should be able to demonstrate that they fully understand their chosen philosophy and therefore be able to present the rationale for their choice of philosophy whilst at the same time being able discuss the alternatives that had considered and explaining why these methods had been rejected.

Epistemology concerns what constitutes acceptable knowledge in a field of study (Saunders, Lewis and Thornhill 2007). Saunders et al describe three epistemological stances: Positivist, Realist and Interpretevist (or phenomenonological). The Positivists philosophy is underpinned by the stance of a natural scientist and represents a style of research which is concerned with facts as opposed to impressions. Realism supports the notion that there is a reality quite independent of the mind. Interpretivism concerns differences in humans as social actors and is relative to way people interpret their everyday social roles in addition to interpreting the social roles of others in accordance with their own understanding. Interpretivism is aims to understand the world from a social actor's point of view whereas Realist and Positivist approaches are concerned with the development of knowledge.

The history of Interpretivism is based on the tradition of phenomenology which is concerned with the way we as humans make sense of the world around us. The theory is grounded in the concept that human thinking is influenced by the things we observe and witness and that these events shape our thoughts and mould our perceptions and beliefs concerning the world around us.

3.2. Research Philosophy

The chosen philosophy for this research will follow the phenomenology tradition. Fisher (2007) suggests that “the research links between interpretations are dialogic”. Fisher concludes that people generally develop their ideas through social interaction with others for example through debates and conversations as well as having internal discussions with themselves.

Interpretative research aims to gather people’s interpretations of how they make sense of the world including an understanding of the structures and processes within it. Burrell and Morgan (1982) suggest that “everyday life is accorded the status of miraculous achievement” therefore the interpretivist paradigm is concerns the understanding and explaining of what is happening on the theatrical stage by attempting to interpret the many scripts and storylines used by the social actors”.

Schon (1983) suggest that “reflective practitioners are professionals who systematically improve their understanding of the professional worlds through reflection, with the support of their professional peers, on their professional activities”. And Fisher (2007) suggests that interpretative research is classed as Gnostic because the tradition does not accept the existence of an orthodox or standard interpretation of events. Fisher (2007) claims that “you cannot understand how others make sense of things unless you have insightful knowledge of your own values and thinking processes known as reflexivity”.

3.3. Research Strategy

The purpose of the phenomenological approach is to identify phenomena by how they are perceived by the actors in the situation. This involves gathering information and perceptions through inductive and qualitative methods such as interviews and discussions. Saunders et al. (2009) suggest that interviews help the researcher to gather valid and reliable date that are relevant to the research objectives. As the research will be based on gathering qualitative evidence semi structured interviews will the most suitable interview method. King (2004) refers to semi structured interviews as “qualitative interviews”.

Adopting an inductive approach is concerned with the context in which an event is taking place and involves interviewing a sample of people to find out their experience of a subject matter.

Saunders et al (2007) state that an inductive approach helps the researcher to gain an understanding of the meanings humans attach to events, and enables a more flexible structure to permit changes of research emphasis as the research progresses. The development of reablement services will have different impacts and meanings for staff working in the public sector and phenomenology will help the interviewer to see situations through the eyes and minds of the research participants.

Husserl (2007) claimed that Phenomenlogical research aims to describe rather than explain and to start from a perspective free from hypothesis or preconceptions. Subsequently, phenomenologists such as Heidegger (1962) modified and built on Hussel's theories and developed the interpretive tradition. Interpretative phenomenologists believe it is impossible to rid the mind of preconceptions and approach something with an empty mind, they believe instead that we use our own experiences to interpret those of others .

3.3.1. Justification for the selected paradigm and methodology

Phenomenological methods are recognised as being particularly effective at bringing to the surface the perceptions of individuals from their own perspectives, and therefore at challenging structural or normative assumptions. Interpretative research methods can be used to inform, support or challenge policy and action.

Many LAs are developing reablement models through restructuring of existing services and the integration of multidisciplinary teams. This creates many practical issues for both organisations because staff from each organisation will be employed on different terms and conditions, are governed by completely different policies and procedures and posses different organisational cultures. Therefore knowing and understanding how these changes affect staff will be an important factor to the research as the research findings and conclusions will be drawn from the respondent's experiences in relation to the subject matter.

Balls (2009) claims that medical staff relate to the phenomenological approach because it places values on the individuals experiences. Oiler (1982) argues that in the nursing profession for example staff are concerned with understanding people, being perceptive and sympathising with them. The profession recognises the validity of individual experiences and supports them in exercising control over their own health care when conducting semi structured interviews the phenomenological researcher will adopt a role that involves acting as facilitator to help respondents talk freely only using questions that seek clarification, illustration or further exploration (Parahoo, 2006).

Interviewing a cross section of staff involved in delivering reablement services will provide an in-depth analysis of experiences that are based on individual accounts of working in reablement teams. Because reablement is a top priority for the NHS and local authorities these interviews should give an insight into how different staff groups are approaching the development of reablement and help to identify cotemporary issues related to partnership working.

An analysis of the respondent's answers will help the researcher to gain a broad understanding of the organisational impact of developing reablement services and this will help to guide and inform the future model that will be developed in LCC. This should be sufficient evidence to answer the research questions.

3.3.2. Rejected methods

Structured interviews were rejected on the grounds that this method is used to collect quantifiable data that is referred to as quantifiable interviews (Saunders et al 2007). This would not be a suitable method as the research is qualitative and aims to understand the impacts of developing reablement services from the respondent's perspective through a process of questions and answers. The structured interview is very rigid and inflexible therefore doesn't allow the interviewer to ask probing questions, this could be a problem if the respondent didn't understand the research question or required more information to answer the question (Bryman 2001).

Unstructured interviews were rejected on the basis that the model is deemed too informal for the purpose of the research topic; this type of interview is non-directed and is more casual than the structured interview method. The risk of using the

unstructured method is that it could encourage the interviewees to diverge from the research topic and talk about irrelevant and inconsequential issues. Consequently this would make it difficult to analyse the data collected.

Non directive interviews were rejected on the grounds that the system is designed to help people to reveal their deep seated and subconscious feelings (Corbetta, 2002) non directive interviews have their origins in psychology and psychotherapy and the drawback is that there are no directions or issues to explore which can create problems in analysing the data.

3.4. Selected methods

Semi structured interviews are none standardised and are frequently used in qualitative analysis. As the research is based on phenomenology semi structured interviews will provide the interviewer with an opportunity to ask probing questions which will enable the interviewer to understand the meanings that participants ascribe to various phenomena (Saunders et al. 2009). The interviewer has the freedom to guide and change the direction of the interview at their own discretion, the interviewer can also prompt the respondent to elucidate further if necessary. Patton (2002) recommends " to explore, probe and ask questions that will elucidate and illuminate that particular subject, to build a conversation within a particular subject area, to word questions spontaneously, and to establish a conversational style but with focus on a particular subject that has been predetermined".

One to one interviews were chosen rather than one to many for interviewing recipients involved in the research. The selected organisations involved in the research were in close proximity to that of the researcher therefore face to face interviews would make it easier to facilitate the interviews as opposed to conducting them over the telephone. Because the researcher would be meeting the interviewees for the first time telephone interviews would make it difficult for the researcher to have full and meaningful conversations with the recipients through telephone interviews.

Collecting the evidence on a one to one basis would allow the researcher to obtain a richer source of information as this form of interview would enable the researcher and interviewee to build a degree of rapport and trust making it a more reliable method into comparison to conducting telephone interviews.

The individuals and organisations selected for interview were identified on the basis that they had either participated in research undertaken by CSED or had experience of developing reablement and intermediate care services in partnership. The participants would be familiar with the chosen subject and would therefore have an understanding and awareness of the associated issues related to the development of reablement services it was on these grounds that the researcher chose not to pilot test the interviews.

3.4.1. Research design

The research concerns the organisational impact of developing reablement services, assessing how local authority and PCT staff are responding to the changes and analysing key success factor across organisations. For the purpose of the research LAs that have or those that are considering developing reablement service were identified. In addition staff within LCC and Liverpool PCT involved directly or indirectly with reablement services was also identified. All parties were contacted by their listed contact points as provided on their website.

Contact was established through phone calls or emails to the appropriate officers seeking their agreement to support the research project. Appointments were organised with all the officers that agreed to be interviewed for the purpose of the research.

Semi structured interview questions were developed around the research question to ensure that the responses provided by the recipients would enable the researcher to collect the appropriate qualitative data for the purpose of the research matter.

The questions primarily focused around the organisational impact of developing reablement services and how these changes potentially affect the workforce with regards to governance, organisational culture and human resource management. The researchers aim was understand how local authority and PCT teams were addressing the areas in question by taking account of their everyday experiences with regards to the reablement agenda. Semi structured interviews were organised with a range of staff that included OTs, home care staff and Social and Health Care Managers. Allied Health professionals were asked their opinions on the effectiveness of working with the LCC ART team to deliver reablement services in addition, views and opinions

were sought at a grass roots level from unqualified practitioners regarding the impact of developing reablement.

3.5. Design of Instrument(s)

Interviews are a systematic way of talking and listening to people and a way to collect data through conversations. Interviews can be a way for individuals to discuss their perception and interpretation with regards to a given situation through self expression. Cohen et al (2000) explain that “the interview is not simply concerned with collecting data about life; it is part of life itself, it human embeddedness is inescapable”.

Organisations that operated reablement teams and intermediate care were identified through the literature review and internet research for the purpose of the research three local authorities were identified.

- Wirral Council
- Knowsley Council
- Halton Council

It was decided to conduct one to one semi structured interviews with these authorities in addition to Allied Health Professionals (Liverpool) and City Council staff such as Occupational Therapists and Social and Health Care staff.

The purpose of the research question is to establish the organisational impact of introducing reablement service. The aim is to analyse the impact from different staff perspectives from across health and social services.

The CSED report (2009) includes evidence about how particular local authorities and health services are strategically approaching the introduction of reablement services. By interviewing a cross section of staff that has direct experience of reablement and intermediate care the researcher would aim to gain a more in-depth understanding from an operational level in terms of identifying the issues from an employee perspective.

Reablement services involve a range of staff from varied backgrounds that have different cultures and histories. The high level expectation is that social service and

health staff work closer together through formal and informal arrangements. In 2010 both organisations are facing difficult budgetary decisions that will create further pressure to integrate services and teams.

Therefore the semi constructed interviews were designed to establish how local authority and health staff respond to organisational issues with regards to organisational culture, governance, medical and social models and roles and responsibilities. This would provide an overview from the interviewee's paradigm as opposed to the organisational context and allow the interviewer to probe and ask questions through conversations and debate. Semi structured interviews will develop broader conversations and help to contextualise the issues of developing reablement services.

3.6. Research procedures

The research was to take place over 6 weeks commencing at the end of February 2010. A gant chart was used to develop achievable timelines for tasks such as contacting the relevant organisations, developing interviews questions and setting up interview meetings and transcribing the interviews.

The internet was used to obtain key contact details for Wirral City Council, Knowsley City Council and Halton City Council. Wirral were contacted by telephone and subsequently by email, Knowsley and Halton were contacted by email. A brief explanation and outline regarding the purpose of the research was sent to key contacts. A telephone call was made to the team leader for Allied Health Professionals and a subsequent interview was agreed. Further interviews were set up via email with Health and Social Care staff.

The researcher sought permission from the Director of Liverpool Primary Care Trust to undertake the research. The researcher sent the Director an outline of the projects aim and objectives, the Director responded by email and approved the research proposal. Permission was also sought from LCC Assistant Director of Adult Social Care, again the request was made by email and the AED responded by email agreeing to support the research project.

Wirral was the first to respond followed shortly by Knowsley and then Halton. Wirral agreed to a face to face interview and a convenient date and time for the interview was negotiated. Following a telephone conversation with the Wirral representative a date and time for the interview was agreed by email. The interview with Wirral took place on at 10.30am on 22nd February 2010 at a Wirral Council district office, the interview lasted approximately 1 ½ hours in total.

Knowsley agreed straightaway to the researchers interview request and the interview took take place on 18th March 2010.The Knowsley representative was the senior lead for intermediate care and suggested that the researcher meet with a selection of social care staff ranging from Home Care Managers to social carers. The original date had to be rescheduled as some of the interviewees were not available on the

agreed date. Following a couple of email exchanges a new date was agreed and the interviews were held on 26th March 2010 at 11am.

An email was sent to the senior lead for older peoples services in Halton; however an automated message advised that the post holder was away on a secondment. The message provided contact details for the post holder's deputy. An email was sent to the named officer requesting their assistance with the research project. The lead officer responded on 23rd February 2010 agreeing to the researchers interview request, interview date was arranged through a personal assistant and the interview was held in Halton on 22nd March 2010 at 9.30am.

The researcher contacted a representative of Allied Health Professionals by telephone. The researcher explained the purpose of the research and provided an outline of the proposed interview process. The AHP representative agreed to assist with an interview and the meeting was held on 8th March 2010 at 2pm. An email was sent to an LCC Health and Social Care Manager requesting an interview, in accordance with the previous interview requests a full explanation was provided and details regarding the interview process were outlined. The HSCM agreed to assist with the interview and also arranged for the interviewer to meet with a Social and Health Carer, the interviews were held on 12th March 2010 at 2pm.

At the start of all the interviews, the researcher provided the interviewee with information concerning the projects aims and objectives and explained how the

interview would be conducted. The researcher clarified with the interviewee that they were clear and understood the process before commencing with interview. The researcher explained the research background and advised that the research was being conducted for a personal research project, participants were thanked for their assistance and assured that all information would be treated in absolute confidence.

3.7. Ethical considerations

Gray (2004) suggests that ethical issues are one of the main concerns when conducting interviews, Gray claims that confidentiality must be given and states that "respondents must not be harmed or damaged in any way from the research, it is important that interviews are not used as devious mean to sell something to the respondent".

Prior to conducting the interviews permission was sought from all participants to ensure that they were happy to be interviewed and comfortable to answer questions as part of a semi structured interview. The interviewer explained the purpose of the inquiry and gave assurances regarding confidentiality; the interviewer informed participants that the interview responses would only be used as part of an MBA research dissertation and would not be included in shaping or informing policy or procedure.

Only willing participants took part in research and the researcher was careful not to apply pressure on internal and external colleagues. The researcher made sure that they clearly explained the purpose of their research and respected the participant's right to privacy and confidentiality. Participants were asked for permission prior to including any qualitative data within the research findings and conclusions.

3.8. Summary

This research project is a qualitative study undertaken through semi constructed interviews. The researcher aims to gather data from speaking and listening to staff that have experience and knowledge of reablement and intermediate care. The purpose is to gather data and not to change the respondents or their opinions. All the evidence will be gathered via face to face interviews involving open and probing questions related to the research question and aims. When the data is gathered and analysed the findings will provide a basis for drawing conclusions and making recommendations.

4. Findings

4.1. Introduction

This chapter presents the findings of the research based on an analysis of qualitative date collected from respondents that participated in semi structured interviews. The conclusions drawn from the research findings and data analysis will be discussed in the following chapter.

Saunders, Lewis and Thornhill (2009) suggest that qualitative data is based on meanings expressed through words and therefore qualitative data are associated with and characterised by the richness and fullness based on opportunities to explore a subject in as real a manner as possible. The researcher adopted an inductive approach as the purpose of the research was to gain an understanding from respondents about their views and experiences of reablement. Saunders et al (2009) suggest that "such research is based on individual's accounts of their experiences and the way in which they explain these through subjective interpretations and relate them to constructions of the social world in which they live".

Saunders et al (2009) argue that "some advocate that researchers should retain the integrity of the data that they collect and commence analysis using the complete notes that are produced through the interview process". The method is referred to as a narrative approach and narrative is defined as an account of an experience that is told in a sequenced way, this form of analysis focuses upon the stories told during the interviews, working on their structures and plots with regard to the social or organisational contexts of the research participant (Saunders et al, 2009).

4.2. Analysis of respondents

The respondents interviewed for the primary research are employed in Local Authorities and the Primary Care Trust. The participants are involved in reablement and intermediate care services. Wirral City Council, Knowsley City Council and Halton City Council all agreed to support the research as did representatives from Allied Health Professionals (Liverpool) and the Assessment and Rehabilitation Team (Liverpool City Council).

4.3. Findings for each research aim

Analysis of the interviews conducted has produced a number of key themes starting to emerge concerning the introduction of reablement. The findings are detailed below in relation to each of the research aims.

4.4. How Local Authorities and Primary Care Trusts are working in partnership to deliver reablement services

4.4.1 Face to Face interviews

The researcher was informed that WCC operates a reablement service in partnership with the PCT. Social Care staff and OTs are based together and share a co-location within Wirral. WCC had been approached by the PCT to develop an enablement service following a decision to close Hospital wards and move OTs into the community.

The aim was to increase levels of independence and reduce the need for long term care packages. The Home Assessment and Reablement Team (HART) was launched in partnership with Wirral Hospital Trust Occupational Therapy Service and the Department of Adult Social Services to provide an assessment and reablement service.

HART has a service level agreement which includes joint funding streams. HART employs 150 social care staff that has been trained by OTs to deliver reablement care packages. Social Care Managers are responsible for managing the social care staff and an OT team manager employed by WCC acts as an intermediary between HART enablers and Wirral Hospital Trust OTs. Referrals requesting social care packages are directed to HART via Wirral's care brokerage service. HART screens all the referrals and selects those most appropriate for reablement. HART is delivered across 3 localities within Wirral and is available between 7.30am to 10.30pm seven days per week. The respondent said that having the social care team and OT team co-located was a key success factor, it emerged that this broke down barriers and encouraged team working and built mutual respect between teams. In general located OTs and reablement teams in the same building counteracted the risk of a blame culture developing and improved relationships through face to face contact. Having a good

understanding of roles and responsibilities was also a key success factor, having this knowledge created an appreciation and respect between OTs and enablers.

LCC delivers reablement through an informal arrangement between Allied Health Professionals (AHP) and the LCC Assessment and Rehabilitation Team (ART). The ART was launched approximately 5 years ago in response to Central Governments drive to prioritise community rehabilitation and reablement. ART provides short term intensive support for a period of 6 weeks; a charge will be applied after the first 6 weeks. ART is a city wide service and is delivered from 7.00am until 11pm over 7 days per week although ART will only accept referrals on a Monday to Friday basis and does not accept referrals at weekends.

ART consists of 100 Social and Health Care Assistants and 6 Social and Health Care Managers. The respondents explained that Liverpool Council had made a decision some years ago to source long term care through the independent sector. As a consequence LCC had reduced its in-house long term home care service through voluntary redundancy and restructuring and refocused home care to deliver short term intensive support at home.

AHP provides community rehabilitation through Occupational Therapy and Physiotherapy. The service is available to adults who are too ill, frail or disabled to travel to hospital for physiotherapy treatment. AHP provides assessment, advice and follow up treatment where appropriate for acute conditions from which recovery can be expected or chronic conditions that may require periodic intervention. AHP provide rehabilitation pathways underpinned by the long term conditions framework to maximise independent living within the community.

AHP have trained ART to undertake basic low level treatment plans devised by qualified therapists. The programmes are delivered in the home environment and therefore eliminate the need to attend a Hospital Clinic or Intermediate Care Unit. It was shown that AHP had confidence in the ability of the ART primarily because they had trained the ART staff themselves and therefore had faith in their ability.

AHP staff are based in a PCT building and ART are sited in a separate LCC building in the Liverpool city centre. The arrangement is not covered by a service level agreement or a section 75 agreement and none of the posts are joint funded. LCC

managers consider referrals from AHP and allocate cases based on the AHP assessment. Initially AHP staff will have no direct contact with the ART worker until an assessment is due. Much of the communication between the two teams is conducted by email and over the telephone, the findings show that this can on occasionally lead to communication breakdowns and tension between staff.

Halton City Council (HCC) reported that in April 2009 the authority reduced its home care service by approximately 850 hours. Prior to the reduction the home care service had delivered long term support, however the organisation was seeking to achieve efficiency savings through the development of a reablement service in response to the Transforming Adult Services agenda. Staff were offered the option of joining the reablement team or leaving through voluntary redundancy.

The reablement service is part of the Intermediate Care service provided by HCC in collaboration with Halton PCT. The structure includes Therapists, Social Workers and Health Care Assistants. HCC is the host organisation and mainstream funding is split between both organisations, the PCT contributes 60% funding and HCC contributes 40% funding, the partnership is covered by a section 75 agreement. The service is available 24 hours over 7 days and as a consequence staff are required to work much more flexibly than previously and subsequently will be required to travel more often between calls.

Prior to April 2009 the Home Care service had operated in silo of the Therapy and Community Nursing teams, however the recent changes had integrated the management of all three areas under a single management structure. The reablement team now shares a building with Therapists and other Community Assessment teams and the respondent said that the having the teams based together improved day to day working relationships. The findings demonstrate that teams that are in close proximity will learn from each other through shared experiences and face to face contact. As an example the finding regarding HCC demonstrated that the co-location had broken down barriers and improved communication, also teams could generally problem solve much easier when they shared an office.

The research findings show that Knowsley City Council (KCC) developed a reablement service in response to the need to deliver Best Value and reduce the cost

of long term care provision. KCC redesigned its existing in-house Home Care Service to focus its resources on delivering reablement support. The study shows that KCC reduced its workforce by 55 care staff and currently employs 70 enablers. Staff that did not wish to join the enablement service were offered the opportunity to be redeployed into a different job, KCC was committed to avoiding compulsory redundancy and therefore staff were found alternative employment within the organisation. Working with the Trade Unions was identified as an important factor to achieving the transition to reablement.

Although the reablement service works in conjunction with OTs and PTs the service is Social Care led. The respondent said that they didn't want a Therapy lead model because this could restrict what could be achieved through reablement concerning risk taking. What emerged was the difference in Health's approach to risk assessment which is more clinically based whereas SS will take a much more holistic view of the individuals needs. The respondent said that OTs will work with a diagnosis and may take the view that a person has achieved their potential, whereas SS will look beyond the immediate condition by considering reablement as a viable option. There was a clear difference in level of risk taking that each organisation was prepared to allow for the purpose of rehabilitation.

4.4.2. Operational Implications

4.4.2.1 Face to Face interviews

One of the significant findings to emerge from this study is that the all the LAs that participated in this study had restructured their in-house home care service to deliver reablement. As a consequence of job redesign home care staff work more flexibly on shifts and rotas over 7 days per week.

This has created a number of problems, for example many of the new job descriptions require essential car use as key criteria however many home carers do not own cars for work purposes. Prior to becoming enablers the staff had been employed as home carers delivering long term care and a lot of their work was static, therefore a car was not a requirement of the job.

Because the changes to staff terms and conditions had been agreed in consultation with Trade Unions the outcome was that staff that didn't meet all the key criteria were still appointed as enablers to avoid making them redundant.

What also emerged was issues related to work force flexibility following restructures and service redesign many LAs reported said that the transition had been extremely difficult quoting examples that showed that staff were highly resistant to the changes involved when transferring from providers of long term care to that of reablement.

A difference in organisational language was something frequently raised as an issue between Health and Social Care providers. SS staff spoke about contract and downtime hours whereas Health were concerned about assessments, changing needs and provision. Health discussed concepts which lower grade social care staff struggle to understand. However what has recently emerged is that integrated Health and Social Care teams seem to be developing a new mixed language which can be understood by members of both organisations.

Another emerging issue is one of trusting and having confidence in the ability of the social care workforce. Wirral reported that when the social care staff first started working with the OTs there were some issues concerning OTs trusting in the ability of social care staff to deliver reablement. This was because the enablers had a background in long term care and the OTs doubted whether the staff could make the transition from being a provider of long term care to being an enabler.

Wirral explained that at first the OTs came across as the "professionals" however over a period of time OTs had become more confident in the ability of social care staff to deliver reablement, the respondent said that this was result of the training the enablers has received from the OTs. In KCC the respondent said that when the notion of developing a Social Care led reablement service was first raised some of the OT staff were sceptical about the idea, however the research suggests that the OTs have come to accept the ability of the Social Care staff because they have witnessed the outcomes that have be achieved.

The study showed a difference in the manner in which Social Care and Health staff approached risk assessments concerning reablement. What emerged was that the Health approach is based on a clinical diagnosis whereas the Social Care reablement assessment will take a much broader view of the individuals needs and stretch beyond the boundaries of the diagnosis, the Social Care assessment will consider the needs of whole person in the context of the wider community agenda.

The Wirral said that changing the title of home carer to enabler had a dramatic impact as staff felt that the title projected a more professional image which helped to change professional and public perceptions about the social care role.

Relationships appear to be strengthened when reablement teams are co-located in the same office. Wirral claimed that the OTs approach to enablement had "rubbed off" and that the enablers had become more outcome focussed as a consequence of working so closely with the OT staff. Locating diverse teams is the same offices is not always easy as one the respondents said that whilst co-locations help build relationships some staff acted quite territorial concerning desks, phones, computers and storage and this was something that had to be taken into consideration when considering co-locations.

There was a concern that using reablement teams to screen service referrals can sometimes lead to conflict with Social Workers (SW). There were examples of SW assessing for more service than is actually required. However KCC said the reablement team had been empowered by the commissioners to increase or decrease care packages however the study has shown that some professional staff perceive the role of reablement staff as a direct threat to their own positions.

AHP said that in some cases they encountered problems because ART staff had failed to carry out a care plan as prescribed. This created concerns as the service users progress was dependent upon the plan being delivered. This situation usually arose when the carer was asked by their manager to attend a different call due to staff shortages which meant that they couldn't fulfil the care plan as it was meant to be delivered. Because the teams didn't share performance targets there was evidence that suggested that the operational managers frequently responded to different priorities.

Health and Social Care teams that operate without a formal partnership agreement can encounter problems concerning governance. The AHP respondent said that this was a major issue because AHP don't have the jurisdiction to ask an ART worker to fit a basic piece of equipment because of differences in organisational standards and competencies. WCC expressed similar concerns regarding differences in organisational procedures; one example was Health's view of medication. Health considers this as a social care task whereas social care views the dispensing of medication as Health task. Some LAs still operate traditional home care policies however the policies had not been adapted the criteria for enablement. An implication therefore is that existing organisational policies and procedures may not entirely fit with the requirements of reablement teams and therefore could be restrictive concerning the duties that enablers may be expected to perform.

The study showed that there can be serious implications when local authority workers assist Health staff with tasks that are not covered by the local authority under health and safety regulations. One example was Social Carers assisting service users with exercise programmes that may need to be performed outside the home. It was not clear which organisation would take responsibility in the event of a reablement worker injuring themselves due to a work related accident.

Reablement staff are trained to NVQ standards however this is competency based training and doesn't include adult reading and writing skills. Many staff employed in reablement are former home carers with a background in long term care. Over the last few years the regulations governing Social Care mean that record keeping is now viewed as an integral part of the job and as such carers are required to keep very detailed records concerning the care delivered. Failure to achieve these standards can result in serious issues concerning the Care Quality Commission and Sage Guarding, working with OTs and other professionals means that reablement staff will be expected to maintain a high standard of writing and record keeping skills at all times.

Integrated reabalment models enable social care staff quick access to minor equipment; prior to HART being launched staff could wait for up to 3 months for basic equipment to be delivered however waiting times had been reduced to 24hours. This meant that service users were more likely to receive minor equipment for example handrails much quicker from a reablement service that was part of an

integrated model. Reablement workers have access to training that enables them to assess for low level equipment however quick access to equipment appears to be dependent on the model being integrated. Reablement workers assessing for low level equipment supports the qualified Occupational Therapists to concentrate on completing complex assessments such as major adaptations and therefore has the potential to free up OTs and thereby reduce waiting lists.

4.4.3 Strategic implications

4.4.3.1. Face to face interviews

A key finding was the number of HART referrals requiring long term care which had been reduced by approximately 75% following HART intervention. Similar results were reported by the other authorities that participated in the study.

WCC said the achievement was a consequence of early intervention, accurate assessment and the provision of low level equipment (appendix i) the evidence demonstrates that between 2009 and 2010 HART dealt with a total of 1483 referrals in total and of this number 930 people didn't require ongoing services following the period of intervention.

Reablement teams have experienced an increase in demand concerning people with high complex needs and that this had started to place RTs under pressure. In some institutions intermediate care beds were being occupied by people that didn't meet the intermediate care criteria because of a shortage of bed capacity in Hospitals and the Community.

The ART statistical report (appendix ii) shows that some of the people that receive support do not meet the criteria for reablement which supports the fact that cases requiring complex long term care are being referred to reablement teams because of either a bed shortage or lack of capacity in the independent sector. ART confirmed that this usually happens when there is bed crisis and as a consequence the service is asked or in some cases instructed to accept people that don't meet the reablement criteria.

Another significant finding was the ability of reablement services to reduce the need for physical support. HART reduced the size of an otherwise complex and large care

package by utilising equipment and minor adaptations provided by OTs. With this additional support the individual was able to live independently without the need for a costly social care package.

The evidence from this study suggests that Local Authorities are using their own in-house resources to deliver the reablement agenda. None of the Authorities that participated in this research have considered using the independent sector to deliver reablement as an alternative to in-house providers. The study found that many of the respondents didn't support the notion of the independent sector delivering reablement. The common feeling was that the independent sector was designed to be a profit making organisation that was more suited to delivering long term static care packages. However there was evidence in KCC of the reablement team working with long term care providers when part of a care package couldn't be provided. When this occurred the reablment teams and independent sector would join resources to ensure that a care package could be provided. KCC respondent said that the independent sector had expressed an interest in providing reablement in the future.

KCC shows that reablement teams can work in conjunction with the independent sector to improve outcomes for people that may have long term care needs. The philosophy of reablment means that enablement staff can guide and help private care agencies to maintain a service user's level of independence throughout the life of the care package which in the long term which could reduce the associated cost of providing long term care.

4.4.4. Summary

3 LAs were interviewed plus representatives from LCC and AHP. The interviews helped the researcher to compare strategies, consider practice and identify common themes concerning reablement. The next chapter will provide an analysis from the findings which will be related back to each of the research aims and conclusions will be drawn from the analysis and presented in the following chapter.

5. Analysis & Conclusions

5.1. Introduction

Having collected the findings for the research project, the data has been collated and presented in Chapter 4. The findings will be analysed and evaluated in chapter five.

Conclusions will be drawn, related back to the research aims, and where appropriate, opportunities for further research identified. Recommendations which may come from the conclusions will be presented in an additional chapter.

5.2. Critical evaluation of adopted methodology

The purpose of this research was to establish the organisational impact of delivering reablement services. An interpretevist approach was chosen because the research involved interviewing practitioners to capture their experiences and views regarding reablement. An inductive approach was the most suitable approach as the aim of the research was to understand the evidence presented from the perspective of those that are involved in delivering reablement.

Semi-structured interviews were chosen as the best interview structure as this would allow the researcher to probe and clarify during the interview process however; the researcher found that interviewee's tended to digress from specific areas of discussion. The respondents were extremely helpful and keen to discuss their experiences however this made it difficult for the interviewer to remain focussed on specific areas of the conversation which tended to roam in different directions making it difficult to record.

Using semi structured interviews encouraged the researcher to become over involved in the discussions and there was a tendency for in-depth conversations to sporadically breakout which although helpful was distracting and time consuming. However semi structured interviews enabled the researcher to carry out a more informative interview than would not have been possible had a structured interview been conducted.

Finally the researcher only chose to interview providers of reablement from LAs and the PCT therefore the findings do not represent the views of service users or commissioners of services such as social workers and other health care

representatives. Therefore the research on represents the views of respondents that act as providers of enablement.

5.3. Analysis/conclusions about each research objective (aim)

The aims of this research were structured to draw out contemporary themes and issues concerning reablement and to identify areas of good practice regarding partnership working between LAs and the PCT.

5.3.1. How are Local Authorities and the Primary Care Trust delivering reablement?

The study has shown that all the LAs that participated in this research have commissioned all long term care provision through the independent sector whilst re-engineering their in-house home care workforce to deliver reablement.

Drake and Davies (2006) argue that LAs are attempting to reduce demand for LTC by re-engineering in-house home care services to promote independence whilst building up capacity in the independent sector.

The change coincides with a national drive to increase primary care in the community by reducing Hospital beds and increasing the number of OTs and Physiotherapists working in the community. The DOH report “Transforming Social Care” (2008) suggests that the transformation of the NHS and SS presents a huge challenge as it affects how professionals engage and work to support people’s needs.

Both organisations are facing massive challenges as they struggle to achieve budget savings and efficiency targets and as a consequence the PCT and SS are increasingly using the skills of OTs and the experience of social care staff to create reablement teams as an alternative option to long term care provision. This often involves integration and collaborative working however this is not an easy process as Davies et al. (2000) describe that the medical culture in the NHS as being “notoriously tribal”.

The transition will be difficult as Wanless (2006) points to the fact the modernisation of health and social services will bring about change in roles and responsibilities of the different professions with the role of social care becoming increasingly important. Reablement involves therapists training and developing social care staff to perform reablement programmes and assess for basic equipment, however this is a function

that the therapists have performed themselves as part of their role therefore the concept of training unqualified staff might appear to be contradictory to the profession (Waddilove 2006).

Health and Social Services operate in different paradigms which can create tensions in the working relationship; Sinclair et al. (2000) reported that in some situations there was evidence of professional uncertainty in the NHS with regard to trusting the judgement of home care staff. Reablement is challenging the traditional boundaries that exist between the Health and Social models of care. McMurray (2006) suggests that the medical model is based on professionals treating a condition through medical means. However reablement challenges these boundaries because it involves non qualified social carers performing roles that would not have been previously possible in the medical model.

Wistow (2001) suggests that one of the risks on integrating social services with the NHS is that the values ands skills that underpin the field of social work and social care will become subordinate to medical or nursing models. However, Health and Social Care teams posses the capacity to learn from each other and the evidence suggests that new cultures and languages emerging.

Wilson et al. (2007) suggests that the relationship between the NHS and Local Government providers has been characterised by arguments and conflict through various reforms and reorganisations. This usually occurs in relation to the role of the NHS as a provider of medical care as opposed to the LA role as a provider of social care. However roles are merging between the professions and the research proves that integrated teams are more successful at resolving their issues than those operated in silo of each other.

Glendinning, Hudson and Means (2005) suggest “that a reoccurring theme is the imbalance between the health and social care sectors, with the NHS commanding most of the resources and taking actions where the consequences impact upon the local authority social care services for instance discharge from hospital to the community”. However the reablement agenda offers a fresh challenge as the reforms mean that the NHS is transferring more of its resources nearer to the community

which suggests that the NHS is increasingly depending on social service providers for help and support.

5.3.2. Assess potential operational implications

All the LA organisations that participated in this study have chosen to restructure their in-house home care service to deliver reablement. The process has involved changing the home carers role from one which "did things for people" to a role that assists people to do things for themselves thereby promoting independence.

Wanless (2006) suggests that the modernisation of health and social services will place greater importance on the role of social care and this is evident by the fact that an increasing number of PCTs are using OTs to train social care staff to become enablers. However there are notable differences in organisational culture between the professions which can make this transition difficult (Davies et al, 2000). The organisations posses different professional infrastructures which work at opposite ends of the health and social care profession and Hall (2005) argues that that "these differences not only pertain to different models of health care underpinning these professions but also relate to deeply engrained factors such as class and gender".

Home care began in an atmosphere of austerity whereby "home helps" would be used to support reasonably fit older people with low level tasks such as shopping, laundry, pension collection, domestic cleaning and lighting fires (Sinclair et al. 2000).

Wistow (2001) discusses how the NHS has "cast social services in the role of handmaiden" a role based on providing just in time contributions to helping to move patients from Hospital and thereby creating room for the next group of patient in need of treatment. However the role of home care is being transformed to deliver reablement and this is challenging the archetypical view of home care as a merely a provider of social care.

Carrier and Kendall (1995) refer to the "concept of a hierarchy of professions" differentiated by full and semi professional status which have contrasting histories and contrasting contemporary circumstances on legal registration and rights to practice. This would explain why some profession doubt the ability of non qualified staff to practice enablement.

Conversely some home care staff have been highly resistant to the changes because the role requires them to work more flexibly leading to some accepting voluntary redundancy. However many staff have embraced the opportunity to gain further training and development opportunities.

There are recorded differences in the medical and social models of care which are described as creating conflict. For example the NHS historically treats people as patients in need of medical repair whereas SS are rather more citizen centred, treating service users as active partners in retaining or regaining their health (Wistow 2001). Reablement represents a fusion of both models however organisational issues such as governance, risk assessment and antiquated policies and procedures can hinder multidisciplinary teams.

Mclenahan and Howard (1999) discuss how partnerships can create tension and conflict and feelings of "take over" distrust and annoyance. Reablement relies on the support of social carers however there is a danger that some professional staff will view the development of the social carer's role as an erosion of the professional role and this could act as a barrier. Gage (1998) suggests that professional cultures are typified as "possessing values that run counter to the spirit of collaboration due to the high value which they place on autonomy" therefore there is an added risk of professional sabotage as reablement represent a shift of power and control.

The role of social care has changed radically however some professionals still have a perception of home carers as providing domestic support therefore they find it difficult to trust the capability and judgement of non professional staff for this reason.

5.3.3. Assess the strategic impact

CSED have predicted that demand for home care will rise as a consequence of those aged 85 rising to 12% by 2012 and 45% by 2022 and this will inevitably lead to an increased demand for social care and support from the Local Authority. The study has found that a consequence of reducing Hospital beds has resulted in an increase of people requiring high complex care being discharged in to the community.

Reablement teams can help the NHS and SS organisations to manage the increased demand by ensuring that all referrals for long term are considered for reablement

before making a final decision regarding long term care. This ensures that people will be afforded the opportunity to regain their independence which if successful may reduce the level of care and support a person may require in the future.

Research in to the cost and outcomes benefits has been conducted by the Social Policy Research Unit (SPRU) at the University of York (Interim Report, Short-term Outcomes and Costs of Reablement Services, 2009) and the results show that reablement is a cost effective alternative to providing long term care.

An analysis of the outcomes achieved by individuals that received a period of reablement shows that significant benefits can be achieved by increasing a person's level of independence. The research showed that on average a reduction of commissioned hours could be been achieved by those undergoing a phase of reablement when compared to a group that had not. Initially these findings represent major efficiency savings and show the gains that can be achieved through reablement.

However, the studies undertaken so far are limited as they cannot distinguish whether the benefits were purely related to the period of reablement, the selection criteria or natural recuperation.

Research conducted by Wanless (2006) suggests there has been a 5% reduction in the number of care home beds and the prediction is that this reduction will continue as Local Authorities attempt to redirect funding to home based support. This coincides with a reduction in the number of hospital beds available which places greater pressure on reablement teams to soak up the shortfall in bed based support.

In addition many LAs are outsourcing long term care provision to the independent sector and restructuring the in-house home care workforce to deliver reablement. The structures of reablement teams are quite small in comparison to teams delivering long term care therefore reablement teams are dependent on quick turn around timescale from start to finish.

Drake and Davies (2006) suggest that restructuring exercises can result in "hollowing out" whereby the outsourcing organisation leaves it self with a skeletal workforce that is unsustainable. The organisations that participated in this study have all made considerable reductions to the home care workforce however this has also coincided

with growth in the independent sector. The priority to reduce long term care means that reablement teams will be expected to cope with a large number of referrals and this will place the reablement teams under enormous pressure as a consequence of the strategy to focus on community support.

Reablement teams offer the most potential for achieving national targets to reduce demand and dependence for long term care. Initially LAs were reducing the home care workforce as part their strategies however some LAs are currently considering recruiting more social care staff to deliver reablement due to increasing demand from commissioning teams.

Future commissioning strategies will need to take this factor in to consideration when conducting an organisational needs analysis to scope future demand. Commissioners will need to ensure that the supply of bed based care is sufficient to meet the actual demand in proportion to the reablement support available.

5.3.4. Analysis/conclusions about the research question

The research question, What is The Organisational Impact of Delivering Reablement Services, aimed to research the implications and impacts of delivering reablement services. The aim was to analyse the impact of delivering reablement and in the process consider the operational and strategic issues that stem from the reablement agenda.

The introduction of reablement is at an advanced stage and many organisations are depending on reablement teams to deliver efficiency savings through the reduction of high cost care packages. LAs are in the main re-engineering their in-house home care services to deliver reablement in conjunction with the PCT. This brings about a shift in organisational culture and workforce changes as the organisations adapt from being a provider to an enabler.

Reablement is high on the national agenda and is at the heart of promoting independence. Organisations that have adopted the reablement model use slightly different structures, some partnerships are formed through formal agreements such as section 75s whilst other organisations choose less formal agreements such as local area agreements.

5.4. Overall conclusions

5.4.1. What is the impact of introducing reablement?

The 1998 White Paper, Modernising Social Services (Secretary for Health, 1998 a) advocated independent living that centred on the needs of individuals and their

families. In the intervening years since the White Paper was first published LAs and the NHS have been transforming the way in which Adult Social Care is delivered through the promotion of independence, prevention and intermediate care. The transition has involved radically changing the roles and responsibilities of health and social care staff.

The National Service Framework for Older People (DH, 2001) highlighted the need to develop services that prevented premature admission to long term care, while in 2006 Our Health, Our Care, Our Say recommended that social care should be delivered closer to home, through improved rehabilitation (DH, 2006) and reablement. The NHS and LAs are jointly responsible for preparing joint strategic needs assessments to develop a strong and sustainable community which includes supporting more people to live independently at home. In previous years Health and Social Services would have taken a different approach based on separate Health and Social Care models of provision and priority. However both organisations are now required to share responsibility for delivering joined up services that support and meet the needs of the wider community through the promotion of partnership working. The change has involved transferring more resources from the Acute sector directly into the community with far more services being provided in peoples own homes than in the previous years.

The 1998 White Paper, Modernising Social Services, places greater emphasis at putting independence at the heart of social services and reiterating that “social services must wherever possible aim to help people to get better, to improve their health and social functioning rather than just keep going” (Secretary of State for Health, 1998). The role of Social Services has been forced to change in response to the priority of promoting of independence. Home care was generally recognised as being a provider of domestic support however recent changes have meant HC adopting an enabler’s role that aims to help people to do things for themselves

through the promotion of independence. To make this transition the PCTs are helping to train and develop home care staff to become enablers which is a very different role to the traditional provider role that home carers were accustomed to delivering in the past. The evidence suggests some professional staff have been concerned about the capability of social care staff to deliver reablement. However the research shows that professionals have more confidence and more likely to trust the ability of social care staff to deliver reablement when they know that the staff have been trained by a qualified OT over a period of time..

The Wanless Social Care Review (2006) Securing Good Care for Older People: Taking a long-term view states that "Preventative services have become increasingly prominent in health and social care policy in recent years, in part to the because of the perceived potential to reduce demand for high intensity, high cost services" (p169).

In response to the national driver to promote independence, LAs and NHS have prioritised re-enablement services and have demonstrated that they are working in partnership together to develop multi-disciplinary reablement teams. The combination offers a blend of clinical experience and social care skills. The mixture of expertise maximises the skills and experience of NHS and LA staff to reduce the demand for long term complex care at home, reduce admission rates to traditional care home settings and avoid unnecessary admission to Hospital. The changes have not been easy for both organisations as they struggle to come to terms with the new ways of working. However the research has shown that some of the most successful reablement teams are those that share a co-location, employ home care staff that have been trained by therapists and have integrated processes and good communication systems in place.

5.4.2. Effectiveness of delivering reablement.

Reablement aims to promote independence by reducing the need for ongoing support or reducing the level of support required and in so doing enabling Social Service departments to achieve efficiency targets.

Martin et al (2004) suggests that due to the diversity in reablement services it is difficult to find evidence based outcomes for patients and to determine efficiency savings. Furthermore Barton et al; (2005) suggests it is difficult to evaluate each

system due to the high level of variance, although Godfrey et al (2005); argue that qualitative evidence from service users suggests promoting independence can make a difference to peoples lives. Promoting independence through reablement affords people the opportunity to benefit from a short but intensive period of treatment that could significantly reduce their need for long term care. Reablement will not work for everybody however the combination of assessment skills and provision of equipment may reduce the need for admission to long term care and prolong a persons ability to live independently or with minimal services for as long as possible.

The research has involved a study of enablement services operated by various authorities. The research showed that on average a reduction of commissioned hours has been achieved by those undergoing a phase of reablement when compared to a group that had not.

5.4.3. Limitations of the study

Only 5 organisations participated in this study, this means that the study may not be entirely representative of the national picture regarding reablement. In addition, only managers and staff involved in delivering reablement were interviewed whereas the study did not consider the experiences of service users and commissioners.

5.4.4. Opportunities for further research

Reablement is largely being delivered by LAs and the PCT working in partnership, however the role of the independent sector with regards to delivering reablement could be further explored.

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List of Appendices

ASSESSMENT AND REHABILITATION TEAM REPORT

	80		**13**		**5**	**4**	**455**		**455**	
w/e 09/04/10	Rehab	37	MAX	8	9	6	Maximum	2610	North	204.5
	Other	47	ICT	2			Hours not available	795	South	97
			Hosps	6			Contact hours	1365	Central	148.5
			CT	0						
	84		**16**		**9**	**6**	**450**		**450**	
w/e 16/04/10	Rehab	34	MAX	7	10	8	Maximum	2610	North	172
	Other	42	ICT	2			Hours not available	760	South	169.5
			Hosps	2			Contact hours	1305	Central	203.5
			CT							
	76		**11**		**10**	**8**	**545**		**545**	
w/e 23/04/10	Rehab	35	MAX	10	10	6	Maximum	2610	North	101.5
	Other	48	ICT	2			Hours not available	760	South	59.5
			Hosps	1			Contact hours	1605	Central	84
			CT	1						
	83		**14**		**10**	**6**	**245**		**245**	
w/e 30/04/10	Rehab		MAX				Maximum		North	
	Other		ICT				Hours not available		South	
			Hosps				Contact hours		Central	
			CT							
	0		**0**		**10**	**6**	**0**		**0**	

HART Grand Summary 2009 - 2010

26/01/2010

Details	Ref	Grand Total	Team 1	Team 2	Team 3	Team 4	Team 5	Team 6
Current Activity								
Number of active cases "Live"	L	139	19	30	18	24	23	25
Number of live cases over 42 days to be investigated		16	0	10	1	2	0	3
Total Number of cases with named Care Manager		746	93	121	124	128	139	141
Number of cases with named OT		733	90	117	111	78	196	141
Number of Care Mangement referrals ending up with a reduced package (including no		734	93	116	122	125	138	140
Number of OT referred people ending up with a reduced package (including no care)		733	91	117	111	78	195	141
Total number of people receiving a reduced package (including no care)		1,467	184	233	233	203	333	281
Referrals								
Number of referrals this year to date		**1483**	183	238	234	210	335	283
Less								
Number of referrals **closed** as inappropriate referral	1	162	20	29	27	32	31	23
Number of people who refused / **turned down** package of care	3	95	18	30	13	6	14	14
Number of people for whom HART were **unable** to provide a service	2	233	18	17	28	24	81	65
Number of referrals were service did not start (zero days)		**490**	**56**	**76**	**68**	**62**	**126**	**102**
Net number of referrals proceeded to service		**993**	**127**	**162**	**166**	**148**	**209**	**181**
Unplanned outcomes								
Number of people went from HART service into **Hospital**	6	138	17	22	26	19	26	28
Number of people that went from HART into **Residential Respite**	9	11	2	2	2	0	1	4
Number of people who went into **Nursing Home**	8	4	0	0	1	1	1	1
Number of people who went from HART into **Intermediate Care Residential**	7	6	1	1	1	0	2	1
Number of people who went into Intermediate care nursing **(Grove House)**	5	2	0	0	0	0	0	2
Number of people who **died** while in receipt of HART service	4	11	2	0	4	2	2	1
Number of people who had an **other** unplanned outcome	10	11	0	3	1	1	1	5
Total number of unplanned outcomes		**183**	**22**	**28**	**35**	**23**	**33**	**42**
Planned Outcomes								
Number of people on completing HART **required a package of care (Keep until 04/09)**		222	43	28	43	39	41	28
Number of people on completing HART intervention required **no ongoing service** (Excludes Live, non actioned, ongoing and unplanned)		930	97	148	140	122	238	185
Number of people completed with an **ongoing Domiciliary Care** Package	11	265	42	55	43	37	42	46
Number of people completed with **no ongoing Domiciliary Care** Package	12	395	42	42	113	62	11	65
Number of people referred from HART to **Direct Payment** Team	13	3	0	3	0	0	0	0
Number of people referred from HART for a **Personal Budget** assessment	14	0	0	0	0	0	0	0
Number of people introduced to **POPIN**	15	0	0	0	0	0	0	0
Number of people entering **employment**	16	0	0	0	0	0	0	0
Additional Information								
People new to DASS no previous service		53	53	83	90	79	130	97
Number of people declining follow on service POST HART		26	26	61	0	2	129	11
Most common length of stay on HART service in weeks		#N/A	6+	6+	2	3	5	6+

Allied Health Interview 8th March 2010 at 2pm

What are the main differences regarding how Health approaches reablement in comparison to Social Services?

What are the main cultural differences between Health led organisations and Social Services?

What is your experience or working with Social Services – what works – what does work so well

How does governance work between ART and AHP

How do you overcome organisational issues such as differences in policies and procedures?

How do you measure outcomes?

Some people think that social care staff are not suitable to deliver reablement becau the perception is that that they are too focussed on doing as opposed to enabling – what's your view?

What are the key success factors to making a partnership between Health and Socia Services work?

Could reablement be delivered through the independent sector?

Does a formal agreement like a section 75 or SLR make any difference ?

What skills and competencies does social care staff need to deliver reablement?